

X-Ray Technician Limited Permit Application

Last Name		First		M.I.
Failure to use your full legal name may result in your application or examination being denied.				
Date of Birth	Social Security Number		Phone Number	
Street or P.O. Box Number		City	State	ZIP Code

Pursuant to the authority found in Section 114870 of the California Health and Safety Code and as required by Section 17520 of the California Family Code, providing the social security number is mandatory. The social security number will be used for purposes of identification. The information on this form may be provided to federal, state, or local agencies for law enforcement purposes. This information may also be provided to the American Registry of Radiologic Technologist for examination purposes. For information or access to your records, contact the Chief of the Certification Unit at the California Department of Health Services, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414, (916) 327-5106.

Permit category applied for. Select only one category below. [Use a separate application for each category requested.]

- ☐ **Chest radiography permit:** radiography of the heart and lungs.
- ☐ **Dental laboratory radiography permit:** radiography of the intra oral cavity, skull, and hand and wrist, for dental purposes.
- ☐ **Dermatology X-ray therapy permit:** application of x-ray to human beings for the treatment of diseases and tumors of the skin.
- ☐ **Extremities radiography permit:** radiography of the upper extremities, including shoulder girdle, and lower extremities, excluding pelvis.
- ☐ **Gastrointestinal radiography permit:** radiography of the esophagus, stomach, small and large intestine, and biliary tract.
- ☐ **Genitourinary radiography permit:** radiography of the kidneys, ureters, urinary bladder, urethra, and internal and external genitalia.
- ☐ **Leg podiatric radiography permit:** radiography of the knee, tibia and fibula, and ankle and foot.
- ☐ **Skull radiography permit:** radiography of the bone and soft tissues of the skull and upper neck.
- ☐ **Torso skeletal radiography permit:** radiography of the shoulder girdle, rib cage and sternum, vertebral column, pelvis and hip joints.
- ☐ **X-ray bone densitometry permit:** radiography of the total skeleton or part thereof, using x-ray bone densitometry.

Complete and return this form along with:

- ☐ A copy of your limited permit X-ray technician school graduation diploma.
- ☐ An application fee of \$75.00 in the form of a check or money order payable to *CDHS-RHB* (California Department of Health Services – Radiologic Health Branch).
- ☐ An examination fee of \$70.00 in the form of a cashier's check or money order payable to *American Registry of Radiologic Technologist*. (The ARRT will not accept personal checks.)

The ARRT can schedule chest, extremities, and/or torso-skeletal examinations in one setting for one fee of \$70.00. You may submit the chest, extremities, and/or torso-skeletal applications together under a cover letter that states the combination of tests for which you wish to sit. On each application, attach a copy of your diploma and application fee. Attach these applications to the signed and dated cover letter with one examination fee.

Dental laboratory radiography permit and Dermatology X-ray therapy permit examinations are conducted by the California Department of Health Services, Radiologic Health Branch. The examination fee is \$75.00 payable to *CDHS-RHB* in the form of a check or money order.

I certify that the information provided with this application is true and correct. I understand that the California Department of Health Services may revoke permits that are procured by fraud, misrepresentation, or mistake, or for the nonpayment of fees. Further, I am aware that it is unlawful to use x-rays on human beings in this state unless I have been granted a permit pursuant to the Radiologic Technology act, I am acting within the scope of that permit, and I am acting under the supervision of a licensee of the healing arts who is a certified supervisor or operator.

Signature	Date
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Mail completed application, copy of diploma, and fees to: Certification Unit
California Department of Health Services
Radiologic Health Branch MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

We will notify you by mail of your status within 30 days. If your application is accepted, we will notify the American Registry of Radiologic Technologists to mail you their instructions for scheduling an examination. Please read those instructions carefully and understand them fully. Your examination fee can not be refunded.